A Field of Hope and Challenges: Lessons from Madison on Building a Sustainable Health Care System

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The cost of health care in the United States is increasing at a rate that threatens the sustainability of the health care system and the budgets of our federal and state governments. According to the Centers for Medicare and Medicaid Services, national health care expenditures currently amount to 17.3 percent of the GDP and will rise to 19.3 percent by 2019 if present trends continue.[1] The ABIM Foundation believes that the medical profession can and must play a leading role in the critical effort to reduce the costs of the system without sacrificing quality. *Medical Professionalism in the New Millennium: A Physician Charter,* is a modern code of medical ethics authored by the ABIM Foundation, ACP Foundation and the European Federation of Internal Medicine, has been endorsed by more than 130 organizations, and includes three fundamental principles: the primacy of patient welfare, patient autonomy and social justice. The social justice principle obligates the medical profession to "promote justice in the health care system, including

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[1] Fact sheet: NHE [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services (US); 2011 Jan 13. Available from: https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp.

the fair distribution of health care resources."[2] Of course, physicians alone cannot be expected to address this deep-seated problem; every stakeholder in the health care system must play a role.

To learn more about how issues of sustainability affect the health care system in one local community, the ABIM Foundation, in collaboration with the Center for Patient Partnerships and the Wisconsin Collaborative for Healthcare Quality, convened a meeting of health leaders from the Madison, Wisconsin area on April 26, 2011. The meeting was titled "Choosing Wisely: The Responsibility of Physicians, Patients and the Health Care Community in Building a Sustainable System." In keeping with the idea that physicians have a crucial but far from solitary role to play in addressing sustainability concerns, the Foundation invited a broad range of stakeholders. Meeting participants included physicians, hospital executives, consumers and patients, employers, public health advocates, national representatives from medical specialty societies, and U.S. Representative Tammy Baldwin (D-WI), who represents Madison in Congress. Members of the group discussed their perspectives on their individual responsibilities with regard to sustainability, ways in which they had succeeded or fallen short in meeting those responsibilities, opportunities for additional successes, and the obstacles to future successes they faced while functioning in a changing environment that makes collaboration increasingly difficult.

The Foundation decided to hold this meeting because its leaders believe that meaningfully enhancing the sustainability of the health care system requires action in one local community after another, and it believes that other communities and national health leaders can learn from a closer look how leaders in a selected community think about the sustainability of their health care system, whether they plan to improve it (and if so, how), and the barriers that stand in their way.

Of all the communities in America, why did the ABIM Foundation choose to convene this discussion in Madison, with a population slightly under a quarter-million? The health care system in the Wisconsin capital region has a number of attributes that are traditionally associated with positive health outcomes and relatively low costs. Structurally, it features integrated delivery systems, a high number of group practice HMOs, and highly regarded hospitals, including a progressively minded academic medical center. Demographically, its people are more likely to have jobs, high levels of educational attainment and health insurance than those of the average American region. (Only 6.8 percent of residents in Dane County, of which Madison is a part, lacked health insurance in 2009.[3]) As one might expect from knowing those basics, Madison performs well on most of the criteria measured by the Dartmouth Atlas. For example, its spending per Medicare enrollee in 2006 was 23 percent lower than the national average.[4] Going to Madison, then, offered the opportunity to learn from success.

Nonetheless, some local observers look at Madison's performance and wonder why it is not doing an even better job. The nearby LaCrosse, Wisconsin region spends even less while achieving higher quality ratings.[5] This disparity suggests another reason to go to Madison–if a region with all its advantages cannot continue to bend the cost curve and deliver greater value, what hope does the rest of the nation have? What needs to happen for Madison to become even more efficient while continuing to provide a high level of care? With the help of local leaders, the Foundation decided to go to Madison and ask.

Of course, physicians alone cannot be expected to address this deep-seated problem; every stakeholder in the health care system must play a role.

[2] ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med [Internet]. 2002 Feb 05 [cited 2011 May 24];136(3):243-46. Available from: http://www.annals.org/content/136/3/243.full

[3] The recession's impact on Dane County: unemployment and poverty rates are up. Madison (WI): Council on Children and Families. 2010 Nov. 2 p. Available from: http://wccf.org/pdf/recession_Dane.pdf.

[4] The Dartmouth Atlas of Health Care: data by region [Internet]. Lebanon (NH): The Dartmouth Institute for Health Policy and Clinical Practice; 2011. Available from: http://www.dartmouthatlas.org/data/region/profile.aspx?loc=208.

[5] The Dartmouth Atlas of Health Care: data by region [Internet]. Lebanon (NH): The Dartmouth Institute for Health Policy and Clinical Practice; 2011. Available from: http://www.dartmouthatlas.org/data/region/profile.aspx?loc=189.

IDEAS FOR IMPROVEMENT AND A TRACK RECORD OF SUCCESS

The good intentions of the people in the room were palpable. Most participants said they believed that change was needed to improve the sustainability of the health care system in the Madison region. They were full of ideas and a sense of community responsibility, and they expressed their desire to build on past efforts to bring together leaders from across the health care community to address significant challenges. For example, many in the room recalled the Madison Patient Safety Collaborative, which was launched in 2000 by three local hospitals that chose to improve quality across their institutions rather than compete with one another on quality grounds. That effort to develop, share and implement patient safety solutions produced concrete results, such as a 20 percent reduction in hospital falls.[6] There also have been significant employer collaborations. Thrive, a regional economic development organization, has devoted extensive energy to promoting wellness.[7] In another example, the Alliance is a cooperative of employers that works to improve health care quality, control costs and engage individuals in their own health care.[8]

Meeting participants exhibited a broad interest in moving beyond effective but inherently limited, tightly-focused collaborations and engaging in a broader, more comprehensive effort to improve the sustainability of the health care system (e.g., new Medicare payment approaches). Some saw a new limited effort as a way to build momentum for a broader collaboration, while others believed the era of more narrowly-defined projects had passed. A robust discussion of the steps that physicians, patients and other health care community stakeholders would need to take to remake the system ensued. The suggested steps, by responsible party, included:

Physicians

Participants suggested that physicians need to do a better job of enabling their patients to play an active role in making decisions about their care. Such shared decision-making could improve the quality of care and reduce costs, as patients often choose less expensive interventions after learning of their options.[9, 10, 11] One hospital leader pointed to the importance of primary care improvements that are already underway, with an increased emphasis on wellness and keeping people from reaching the conditions when costly interventions are needed. Participants also said that physicians need to educate themselves about cost issues, as many are insulated from the cost implications of their daily decisions.

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[6] Three hospitals in Madison, Wis., extend the work of a falls team started by a patient safety collaborative [Internet]. Princeton (NJ): Robert Wood Johnson Foundation. 2010 May 27. Available from: http://www.rwjf.org/pr/product.jsp?id=63954.

[7] Thrive here: in the Madison Region [Internet]. Madison (WI): Madison Regional Economic Development Enterprise; 2011. Available at: http://thrivehere.org/.

[8] The alliance: employers moving health care forward [Internet]. Madison (WI): The Alliance. Available from: http://the-alliance.org/.

[9] Braddock CH, Edwards KA, et al. Informed decision making in outpatient practice. JAMA [Internet]. 1999 Dec 22 [cited 2011 May 24];282(24):2313-20. Available from: http://jama.ama-assn.org/content/282/24/2313.short

[10] Browne K, Roseman D, et al. Analysis & commentary: measuring patient experience as a strategy for improving primary care. Health Affairs [Internet]. 2010 May [cited 2011 May 24];29(5):921-25. Available from: http://content.healthaffairs.org/content/29/5/921.abstract

[11] O'Connor AM, Llewellyn-Thomas HA, Flood AB. Modifying unwarranted variations in health care: shared decision making using patient decision aids. Health Affairs [Internet]. 2004 Oct [cited 2011 May 24]:Suppl Web Exclusives:VAR63-72. Available from: http://content.healthaffairs.org/content/early/2004/10/07/hlthaff.var.63.full.pdf+html?sid=59404baa-ff08-44ca-bbcd-39ab061d93d8

Patients/Consumers

The health leaders agreed that patients and consumers are crucial in any effort to control health care costs. First, they need to engage with their physicians as active participants in their care, articulating their desired health outcomes; second, that engagement needs to be informed by an understanding of the financial implications and consequences–for themselves and society as a whole–of their care preferences. The health leaders understood, however, that a significant educational effort will be required to enable patients and consumers to play these roles.

This education could come from a variety of sources, including health plans, physicians, government agencies and employers. As mentioned above, physicians have a role to play in helping their patients become active in their care. Madison also benefits from an active employer community, and a number of participants stressed the opportunities for employers that interact frequently with their employees regarding health care to advance the wiser use of health care resources. Ideas included educational efforts about generic drugs and providing for health coaching and risk assessments. It was suggested that employers should use their leverage as purchasers to persuade insurers to align financial incentives to promote value.

Participants also suggested that patients' understanding of their role in driving the costs of the health care system should be reinforced by employer and insurer incentives that encourage individuals to be responsible stewards of valuable health care resources across their communities.

Medical Groups/Hospitals

Finally, medical groups and hospitals also have a major role to play. First, they can actively root out waste and inefficiencies in their own systems. Second, they can make investments in electronic health records and other innovations that can increase the efficiency and effectiveness of the care their institutions offer. Third, they too can promote shared decision-making and collaborative relationships between their professionals and patients. And fourth, they can think about the services their community needs and ways to shape their offerings to align with those needs, rather than offering duplicative services that may tend to create their own demand.

THE CHALLENGES OF COLLABORATION

"We are well-positioned to move forward as a community, but we lack the infrastructure of collaboration." These words, from a patient advocate who attended the meeting, go to the core of why many participants believed organizational impediments would make change so difficult, despite the long list of potential improvements suggested. Like most communities, Madison features competition among health care providers, including three hospital systems. This competition has led to an arms race of sorts, featuring the duplication of services at competing facilities. One hospital executive suggested that competition is likely to become even fiercer in the years ahead, and one employer representative voiced fears that the growth of accountable care organizations will diminish providers' ability to focus on those services at which they excel.

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As it is increasingly clear that the supply of medical services can create demand, this level of competition exerts a powerful upward pull on costs.[12, 13] One clinician suggested that competitive pressures also make it more difficult for clinicians at competing institutions to share lessons learned.

To achieve the changes they had discussed, one business leader said the community stakeholders "need to be clear about when we're collaborating and when we're competing." In the absence of such an understanding, the leaders in the room were skeptical that they could turn their ideas into reality and make meaningful progress in controlling costs. Despite the seemingly frank discussion, the meeting may have only scratched the surface of the difficulties competition presents for efforts to manage resources more effectively. In a subsequent survey of meeting participants, one person commented that "we kept dodging the big issues and solutions while talking about 'collaboration.'"

Of course, numerous factors, including legal restrictions and business pressures, make it challenging to work cooperatively. Participants thought these obstacles could be overcome, but only when true vision and leadership eclipse self-interest. Unfortunately, they also were divided about whether the sense of urgency that may be required to spur that vision and leadership was present. A few in the room believed they were standing on a "burning platform" that would make inaction unacceptable; more did not, pointing to high commercial reimbursement rates and a lack of consensus among stakeholders that action was urgent. This group pointed to the idea that, although the regional health care system faces severe challenges, its day of reckoning, while surely coming, is still somewhere in the distance. In the meantime, levels of compensation for health systems, physicians and other stakeholders remained high.

Moreover, stakeholders in Madison face significant disincentives to initiating efforts that would lead to a reduction in the level of care they provide, with an accompanying loss of revenue. "The systems that have worked to become more efficient have lost revenue and have not been rewarded with more market share," according to one policy expert. Addressing this "first mover disadvantage" will be key to achieving landmark change, in Madison and other communities around the nation. One employer representative suggested that employers had to take responsibility for rewarding providers that delivered higher quality at lower costs, so that providers would see efficiency as helping rather than harming their bottom line.

In addition to the tension between collaboration and cooperation, an uneven sense of urgency, and the rational fear of acting alone, participants suggested additional barriers block a major effort to address the Madison health system's sustainability. Some suggested that the health community still does not engage consumers effectively in the system. One physician stated that the political climate makes it difficult to talk about resource conservation, as any effort to reduce costs will reflexively be termed an effort to ration care.

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[12] Roemer MI. Bed supply and hospital utilization: a natural experiment. Hospitals. 1961 Nov;I(35):36-42.

[13] Wennberg JE. Tracking medicine. New York; Oxford University Press; 2010. 128-29 p.

WHERE TO GO FROM HERE: AN OUTSIDE FORCE?

Taken together, the barriers discussed in the previous section were sufficient to give pause to even the well-intentioned and generally optimistic system leaders who gathered that morning. At the same time, their experience working together to solve challenging problems and their sincere interest in preserving the sustainability of their region's health care system demonstrated the promise of Madison. In addition, the energy of the business community offered reason for hope, since business leaders had provided the initial energy for earlier collaborative efforts and have vehicles to work together to improve health care quality and control costs.

At the close of the meeting, many participants agreed to meet again to discuss the cost and quality challenges facing their community; in a subsequent survey, 89 percent of those who responded said they were likely or very likely to participate in follow-up activities. Some pointed to local entities that could facilitate continuing discussions, including the local county health council, the United Way and Representative Baldwin. Others believed figures from outside the community might be needed to guide those discussions to help overcome inertia and other barriers. This admission speaks volumes about the challenges communities face, as well as the difficulty of achieving change at the local level. A government agency or a nonprofit with significant resources may need to devote itself to shepherding regions through the process of revisiting their health systems. (Having states become directly involved might address some of the antitrust concerns that may prevent providers from collaborating on efforts to improve quality and reduce cost.)

CONCLUSION

In this time of rapid change, Madison is at a crossroads, with organizations deciding whether to proceed with sustainability efforts individually, collaborate, or simply perpetuate a system that is currently more efficient than those of most communities but has not reached its potential and very likely will slide backward if preventive efforts are not undertaken. The meeting highlighted the desirability of collaboration between the leaders of competing systems and the difficulties in obtaining it, demonstrating the possibilities—and limits—of ad hoc efforts to work across stakeholders on specific health issues while leaving the system's fundamentals intact. Most importantly, it showed the tremendous interest on the part of health system leaders in addressing sustainability and the frustration they feel about their inability to do so. Any meaningful effort to control the ever-rising cost of health care will require a solution to problems such as those faced by Madison's leaders.

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NOTES

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